Invasive Streptococcal Disease Case Report
Texas Department of Health — IDEAS Division
Austin, Texas (512) 458-7676

PATIENT INFORMATION

Name:_____
Last **First** **MI**

Address:_____
Street **City** **County** **Zip**

(_____)-_____ _____/_____/_____ _____ _____ (W = white, non-hispanic; B = black, non-Hispanic; H = Hispanic; N = Native American; A = Asian; O = Other; U = Unknown)
Phone **Birth Date** **Gender** **Race/Ethnicity**

MEDICAL INFORMATION

_____/_____/_____ **Hospitalized?** _____ _____ _____/_____/_____ _____
Onset Date **Yes** **No** **Admit Date** **Hospital Name**

_____ (_____)_____ **Outcome (check one):** _____**died** _____ **recovering**
Physician Name **MD Phone**

_____/_____/_____ **Type of Infection:** _____ **bacteremia** _____ **pneumonia** _____**STSS** _____**NF** _____**meningitis** _____**sinusitis**
Discharge Date
_____ **otitis media** _____ **endocarditis** _____ **peritonitis** _____ **septic arthritis**

Other (specify): _____

Did patient have a history of (check all that apply): _____**diabetes mellitus** _____**HIV/AIDS** _____**asthma** _____**drug abuse** _____**alcohol abuse**

_____ **past smoker** _____**current smoker** _____**stroke** _____ **sickle cell disease** _____**organ transplant** _____**malignancy** _____**splenectomy/asplenia**

_____**chronic lung disease** _____**chronic heart disease** _____**renal failure** _____**other immunosuppressive disease (specify)**

LABORATORY INFORMATION (please attach lab report if available)

_____/_____/_____ **Culture obtained from (check one):** _____ **CSF** _____ **Blood** **Other sterile site (specify):** _____
Date of Test

***Isolate sent to TDH** _____**Yes** _____**No** _____**Unk** **Date sent to TDH**_____/_____/_____

*Invasive isolates of streptococcus pneumoniae in children < 5 years of age who have been previously vaccinated only.

Bacterial Species (check one): _____**Group A strep (*S. pyogenes*)** _____**Group B strep (*S. agalactiae*)** _____**Streptococcus pneumoniae**

Comments: _____

_____

VACCINATION HISTORY

Did the patient receive the Pneumococcal vaccine? _____**Yes** _____**No** _____**Unk** **If yes, please complete the following:**

Date given: _____/_____/_____ **Vaccine Name/Manufacturer** _____ **Lot Number** _____

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Date given: _____/_____/_____ **Vaccine Name/Manufacturer** _____ **Lot Number** _____

REPORTING INFORMATION

_____ _____ (_____)_____ _____/_____/_____
Reporting Person **Reporting Facility** **Phone number** **Date of Report**

Stock Number E59-11574
Revision date 10/21/2003